

Londesborough Court Limited

William Wilberforce

Inspection report

West Green
Pocklington
York
North Yorkshire
YO42 2NH

Tel: 01759302294

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

William Wilberforce is a care home which provides accommodation and personal care for those who may have dementia or a physical disability. The service can support 64 people in one adapted building. At the time of the inspection 62 people were using the service.

People's experience of using this service and what we found

People who required staff to administer their medicines did not always receive the right support. We could not be assured that staff followed the prescribers' instructions when administering time specific medicines to people. People were not always offered the opportunity to express to staff if they required pain relief.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

The provider's quality assurances systems had not identified the concerns we found during the inspection. The audits in place were not robust and lacked detail to evidence what had been reviewed as part of the audit. Records to support the safe management of medicines and records to show the service followed the principles of the Mental Capacity Act (MCA) were not always completed.

People were happy living at the service. Staff engaged with people in a meaningful way and respected their diversity. Risks to people were assessed and reviewed on a regular basis. Staff were recruited safely and understood the principles of keeping people safe.

For more details, please see the full report which is on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection.

The last rating for this service was good (published 25 October 2019).

Why we inspected

We received concerns in relation to staffing levels and seeking medical attention in a timely manner. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for William Wilberforce on our website at www.cqc.org.uk.

Enforcement and Recommendations

We have identified breaches in relation to safe management of medicines and management oversight at this inspection.

We have made a recommendation in relation to the provider following the principles of MCA and regarding analysis of themes and trends related to accidents and incidents.

Please see the action we have told the provider to take at the end of this report.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

William Wilberforce

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team

The inspection was completed by 2 inspectors.

Service and service type

William Wilberforce is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. William Wilberforce is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us

annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with the registered manager, senior carer workers, carer workers and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with 6 people who used the service about their experience of the care provided and 4 relatives. We reviewed a range of records. This included 5 people's care records and multiple medication records. We looked at 3 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- Medicines were not always managed safely.
- We identified discrepancies with the administration of time sensitive medicines. People who were prescribed medicines that were required to be taken 30 to 60 minutes before food were administered with medicines that were required to be taken with food. We spoke with a member of staff who told us these medicines were administered all at the same time. This was not in line with prescribing instructions.
- Staff did not always follow best practice when administering 'as and when' required medicines.
- Protocols for 'as and when' required medicine were not always accessible to staff to guide them on when and how the medicines should be administered.
- The registered manager completed monthly medication audits. However, these did not identify the concerns we found during the inspection.

Whilst we found no evidence people had been harmed, people had been placed at risk of harm as a result of the issues we found. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Following the inspection, the registered manager responded to the concerns raised regarding the management of medicine and put plans in place to address the areas identified.

Learning lessons when things go wrong

- There were a high number of recorded accidents and incidents at the service over a three-month period. The registered manager reviewed all incidents and accidents. However, the analysis was not sufficiently detailed or robust at identifying themes and trends to learn lessons.

We recommend the provider looks at best practice guidance relating to identifying themes and trends and update their practice accordingly.

- Staff recorded accidents and incident in detail.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- We found the service was not always working within the principles of the MCA, there were no records to show people's capacity was assessed prior to decisions being made in their best interest.
- There were no records to show conditions related to DoLS authorisations were being met.

We recommend the provider seeks guidance on the principles of the MCA and update their practice accordingly.

- Appropriate legal authorisations were in place to deprive a person of their liberty.

Systems and processes to safeguard people from the risk of abuse

- People felt safe at the service. People told us, "I am safe here, the staff come when I need them" and "Yes, I feel safe, it's a nice place."
- Staff knew what action to take to ensure people were safe and protected from harm and abuse.
- The service had a safeguarding policy in place and the management team followed internal and external processes to keep people safe.

Assessing risk, safety monitoring and management

- Risks to people were recorded, managed appropriately and reviewed on a regular basis. Care plans and risk assessments were detailed and provided staff appropriate guidance to support people safely.
- Fire safety was managed effectively. Staff took part in fire drills and knew how to safely evacuate people from the premises.
- Staff were observed supporting people safely with moving and handling.

Staffing and recruitment

- People were supported by a sufficient number of staff.
- Observations on the days of inspection were that staff were always around and we did not hear call bells ringing for long periods of time.
- Staff were recruited safely; appropriate checks were carried out to ensure staff were suitable to work with vulnerable people.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

- The service accommodated visiting in line with current government guidance.

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Auditing processes and systems were in place to review and monitor the quality of the service. However, audits lacked detail to evidence what had been reviewed as part of the audit.
- Audits did not always identify potential risks to the safety of the service or people. For example, audits carried out for the safe management of medicines had failed to identify risks people were exposed to regarding their time specific medicines.
- Staff felt supported within their role. However, yearly appraisals had not been completed since 2020. The registered manager immediately addressed this following the inspection and commenced appraisals with all staff.
- Records relating to people's capacity and decisions made in their best interest were not always completed to show that the requirements of the Mental Capacity Act 2005 had been followed. The registered manager lacked understanding regarding their responsibility to ensure capacity assessments and best interest decisions were completed.
- Records to support the identification of people and their allergies were not always in place to support staff to administer medicines safely.

Failure to maintain accurate, complete and contemporaneous records and assess, monitor and improve the quality and safety of the service was a breach of Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager promptly acted on the feedback from the inspection and demonstrated what action was to be taken to address the areas of concern identified.
- People spoke positively about the registered manager and the provider and told us that they were always around if they needed them. One person told us "[Providers name] and [registered managers] name are always around if we need them for anything."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider, registered manager and staff promoted a positive culture which ensured person centred care for people.
- Staff recognised people's diversity and demonstrated respectful compassionate care when engaging with them.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others

- The registered manager was aware of their responsibilities under the duty of candour. Legally services have to inform CQC and the local authority of certain significant events that happen at their service. This obligation had been met.
- Health professionals were confident that the management and staff team raised concerns in a timely manner and act appropriately to recommendations given.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

- People, their relatives and stakeholders were given opportunities to feedback regarding the care provided and running of the service.
- The registered manager focused on continuous learning by seeking support from professionals to improve people's safety and wellbeing.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure the safe management of medicines. 12(2)(g)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure accurate, complete and contemporaneous records were in place. The provider failed to assess, monitor and improve the quality and safety of the service. 17 (1), (2) (a),(c),(d)(i)